California MEDICINE

EDITORIAL

## The Medical Services Commission

AS THE TERM itself implies, and to the extent that its growth and development are the concern of both a profession and a business, health insurance is a hybrid creature torn between the ethics, traditions and customs of medicine and the practices and standards of the insurance industry. When, to the term "health insurance" is added the modifier "compulsory," the creature degenerates from hybrid to mongrel, and the conflicts of interest between profession, business and bureaucracy increase from the warm to the inflammatory.

Most of the roadblocks in the orderly development of voluntary health insurance have been the result of the basically antithetic points of view of the medical profession and the insurance business and the consequent inability of each to see the big problems of health insurance through the eyes of the other. Good medicine may well seem to be poor business, and the reverse may also sometimes be true.

It is obvious that voluntary health insurance can succeed only if it be based both on sound business practices and on valid ethical principles of good medicine. But, too often, the seemingly only possible solution to any given problem of health insurance fulfills only one of these criteria.

The medical profession has accepted health insurance as a modern social need. Having done so, it has assumed a degree of responsibility to make it work. And obviously, if it is to work, these apparently irreconcilable conflicts between the traditions and ethics of medicine and the standards of good business must somehow be resolved. To resolve them, the medical profession must first determine those elements of ethical medical practice with which health insurance, to be good and acceptable, must not interfere. Further, it must delineate those modifications of the traditional pattern of medical practice which the profession can accept as being necessary if the insurance principle is successfully to be applied to health costs. So far, then, as medicine is concerned, the basic questions are: Of which of its jealously guarded customs and traditions must the profession accept modification, and upon which must it stand as upon the ramparts, permitting no breach of their tenets?

To forge an instrument to pursue these answers, the House of Delegates of the California Medical Association at its annual session in April 1952 adopted a resolution creating a Medical Services Commission. To quote the resolution: "... a permanent Medical Services Commission ... is hereby created whose function it shall be to study, keep records upon and recommend action to the California Medical Association and its component bodies on all types of prepaid medical care, including C.P.S., insurance company plans, industrial accident schedules, union labor plans, voluntary, compulsory, governmental and non-governmental plans ..." The Commission is to consist of nine members, serving staggered terms of three years. That Com-

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mission has been appointed, organized and is now functioning.

At the beginning of its work, the Commission will undoubtedly lean heavily on the enormous amount of relevant and already codified data accumulated by the still-functioning C.M.A.-C.P.S. Study Committee. But, to serve its highest purpose, the Commission must distill from this data good answers to the question of what role the medical profession should and must play in the broad socioeconomic field of health insurance.

May we hope, or perhaps might we better pray, that the Medical Services Commission will measure up to its opportunities and its responsibilities—the manner and degree of their fulfillment may well shape in large part the future of the private practice of medicine.

**MEDICAL SERVICES COMMISSION**

The members of the Medical Services Commission, recently appointed in compliance with a resolution passed by the House of Delegates, are:

| | | Term Expires |
|---|---|---|
| LESLIE MAGOON, M.D., chairman | San Jose | 1955 |
| RALPH TEALL, M.D., vice-chairman | Sacramento | 1955 |
| HOLLIS L. CAREY, M.D. | Gridley | 1955 |
| HENRY GIBBONS III, M.D., secretary | San Francisco | 1954 |
| EDWARD C. ROSENOW, M.D. | Pasadena | 1954 |
| H. GORDON MACLEAN, M.D. | Oakland | 1954 |
| E. R. LAMBERTSON, M.D. | Los Angeles | 1953 |
| JAMES B. IRWIN, M.D. | San Diego | 1953 |
| E. ERIC LARSON, M.D. | Los Angeles | 1953 |

## *LETTERS to the Editor . . .*

I AM WRITING YOU with reference to the article "Relationship of Delivery Date to Predicted Date," by Dr. Edward Liston, CALIFORNIA MEDICINE, 76: 395, June 1952. I feel that Dr. Liston's conclusion, "the data confirm a clinical impression that delivery is twice as likely to be late as early," is a rather devious statement of the facts he observed. It would seem more fair to state that the prediction of delivery date as 280 days after the first day of the last menstrual period was in error, and that the date should be chosen as either 283 or 284 days. In this case, the median point of the data would be more exactly expressed. In view of the common tendency of humans to be impatient, I suppose it would be better to use 284 days so that a few more people would deliver early than late. Judging by the slight irregularities in the data submitted, I would think that 1300 consecutive deliveries are probably too few on which to base such conclusion in any event, since a smooth curve of the normal distribution type would be expected. A series of perhaps ten times this number might give a better evaluation of the point Dr. Liston makes, although it may well be correct that a prediction of 280 days is too few for the average woman.

I am dropping this note to you in the interest of better statistical practice; I am sending Dr. Liston a copy, but whether you choose to publish it or not does not appear to me to be of any great importance.

LEWIS G. JACOBS, M.D.,
Oakland

IN REPLY to Dr. Lewis G. Jacobs' letter, I realize that the delivery dates of women in Palo Alto do not "prove" a universal rule valid, for example, in London or Shanghai. The figures I collected do what they were expected to do—confirm to my satisfaction a strong pre-existing clinical impression that more women deliver after the standard predicted date than before the standard predicted date which is accepted as 280 days after the first day of the last menstrual period.

If Dr. Jacobs wishes to change the standard prediction tables to a 284 day basis, I have no objection. The chart suggests, however, that 280 days is a good enough rule of thumb since it seems to be in the middle of the six-week period in which delivery usually takes place.

Dr. Jacobs writes, "in the interest of better statistical practice." After consulting an authority on statistics and forecasting, I find that no apology is necessary for my "statistical practice" in this instance. The data were taken at random; they were adequate in number; and they produced a sufficiently smooth curve. Dr. Jacobs makes the assumption that with ten times as many cases "a smooth curve of the normal distribution type would be expected." There is no statistical expectation that a bell curve, which applies to the distribution of purely chance characteristics, would necessarily apply to a natural phenomenon such as the onset of labor. Multiplying the cases by ten or by a hundred would not be likely to change the character of the skewed curve produced by 1,300 cases to a symmetrical bell curve or any other type of curve.

EDWARD LISTON, M.D.,
Palo Alto